

Supplement Benefit Employer Trust

Vision List Enrollment Form (for initial enrollment)

Group Name: _____

Employee Name (Last Name, First Name)	Social Security Number	Date of Birth	Gender M/F	Date of Full Time Employment	Dependents to be Enrolled		Cal-COBRA or COBRA Y or N
					Spouse (Y/N)	# of Children < age 25	
<i>Smith, Todd (sample)</i>	<i>987-65-4321</i>	<i>12/19/59</i>	<i>M</i>	<i>11/03/88</i>	Y	2	N
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Please make blank copies of this page for additional employees.